New Jersey Department of Health and Senior Services
Clinical Laboratory Improvement Service
PO Box 361
Trenton, NJ 08625-0361

TRANSFUSION REACTION REPORT

INSTRUCTIONS:

1. *As of May 21, l984, in compliance with Chapter 8 - State Administrative Code: Collection, Processing, Storage and Distribution of Blood, Regulation 8:8-5.2(a)1., any hemolytic or life-threatening transfusion reaction must be reported within 10 days of occurrence.*
2. *Forward the original copy of the report to the address listed above; retain a copy for your records.*
3. *If there are any questions, contact the Blood Bank Unit at 609-292-0522.*
4. *Briefly summarize the events leading to the reaction below. Attach copies of the transfusion reaction work-up performed.*
5. *Describe corrective action(s) taken to prevent error from recurring.*

Name of Blood Bank		Telephone Number
Date of Transfusion	Time of Transfusion	Day, Date & Time of Reaction
Amount of Blood Transfused	Patient ABO Group	Donor ABO Group
Location of Patient at Time of Reaction		
Patient Name	Patient Age	Diagnosis

Type of Reaction

- ☐ Fatal ☐ Non-Fatal
  - ☐ Hemolytic
  - ☐ Anaphylactic
  - ☐ Delayed Hemolytic
    - ☐ a. Amount of time after transfusion _____
    - ☐ b. Specify antibody, if applicable _____
  - ☐ Bacterial (List Organism) _____

Describe Events Leading to the Reaction and Corrective Action Taken (If more space is needed attach additional sheets.)

Date Reported	Name of Blood Bank Director	Signature of Blood Bank Director

Forward completed Report to address listed above; retain a copy for your records.